



Protecting health and health services in the services negotiations of the Economic Partnership Agreement (EPA) between East and Southern African (ESA) countries and the European Union



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Negotiations are underway on the services agreements towards concluding a full and comprehensive Economic Partnership Agreement (EPA) between East and Southern African countries (ESA) and the European Union (EU). The services negotiations will impact on health services and access to health care. The brief outlines the issues affecting health services, and presents options for ESA negotiators to ensure that the negotiations meet international and African health and human rights commitments, use available trade flexibilities, promote public health and ensure adequate assessment and information to support the negotiations.

The Economic Partnership Agreements and services negotiations

Interim Economic Partnership Agreements (IEPA) were agreed on towards the end of 2007 within the twenty year Cotonou Partnership Agreement (CPA) signed in 2000 between the EU and 77 African, Caribbean and Pacific (ACP) countries, with two separate agreements covering different Southern African Development community and East African states (see Policy brief 17 for more information on this, the issues involved and the health implications). As none of the African negotiating groups was able to reach a final agreement on EPAs, most initialled the IEPAs with the EU to avoid trade disruption. The African Union and the Economic Commission for Africa in 2008 have noted the need for a development chapter in the EPAs that puts development clearly at the centre of the EPA, including references to overcoming major trade-related constraints, achieving certain satisfactory living standards and promoting regional integration.

As part of this, EQUINET noted in 2008 (policy brief 17) the need to explicitly include in the EPA a commitment to interpret and implement any clauses in a manner supportive of ESA countries right to protect public health; to protect TRIPS flexibilities (with no TRIPS plus clauses), to exclude any commitments to liberalise health services; and to include provision for assessment of health impact in health related sectors where commitments are proposed. The ESA-EC IEPA did not integrate these requirements, so this is still a matter for the ongoing negotiations. The SADC-EC IEPA did explicitly protect health by providing, in Article 3, a clear statement that the application of the agreement shall take into account the human, cultural, economic, social, health and environmental interests of the population and of future generations.

While the road map to taking forward the full EPA negotiations is still to be concluded, negotiations started in 2008 /9 within areas of the EPA covering six clusters of trade issues, namely: development issues, market access, agriculture, fisheries, trade in services and trade related issues, as well as the institutional framework for cooperation and the process for dispute settlement.

This brief outlines the issues and options for protecting health and equitable health services within the services negotiations of the EPAs. It summarises evidence available in more detail in the list of resources at the end of the document.

The context for the services negotiations

The services negotiations are taking place within the wider context of the World Trade Organisation General Agreement on Trade in Services, as well as the unfinished negotiations requiring WTO member countries to liberalise their service sectors by indicating the sectors being opened to foreign competition. With an increasing volume of global trade in services, and with services making up a high proportion of economic activity in developing countries, the November 2001 WTO Ministerial Conference in Doha in paragraph 15 of its declaration stated that, *“the negotiations on trade in services shall be conducted with a view to promoting the economic growth of all trading partners and the development of developing and least-developed countries.”* Developing countries have raised that the Doha Development Round should address this in a manner that protects affordable, accessible, universal essential services including health, education, water, electricity, social housing, with policy space to regulate the provision of these services and to provide for non market principles of universal coverage, financial protection and cross subsidies through domestic policies that are in tandem with development priorities. Few countries have thus committed their health services to liberalisation under GATS, preferring to determine the pace and nature of any market opening within reversible domestic policies. Only Burundi, Malawi, Rwanda, Zambia and Congo RP have made GATS level commitments in the health sector. Other countries in the region are not bound by WTO level commitments to liberalisation of their health sectors and thus have the policy latitude to address this at national level.

Issues for the services negotiations in relation to public health

The lack of transparency with respect to the documentation of the services negotiations undermines informed analysis. Official documentation on the numerous technical or political level meetings covering the services negotiations is not publicly available. This brief thus raises issues that are of concern from a public health perspective, that would need to be taken into account to protect health or health care services, noting that these are key areas of human rights and state obligation in both ESA countries and the EC.

The umbrella Cotonou Agreement of June 2000 explicitly commits EU and ACP states to observe international agreements, many of which have direct and indirect links with the provision of health services. Article 19.2 of the Agreement is a very important provision in this context. The provision reads:

“Cooperation shall refer to the conclusions of United Nations Conferences and to the objectives, targets and action programmes agreed at international level and to their follow up as a basis for development principles. Cooperation shall also refer to the international development cooperation targets and shall pay particular attention to putting in place qualitative and quantitative indicators of progress.”

Article 25 of the Cotonou agreement clearly commits to the development of the social sector. Article 31 commits to ensuring gender equity in access to health services, while Article 34 provides that economic and trade cooperation shall have due regard for the ACP States’ political choices and development priorities.

At the same time, the signals being sent that liberalisation of *all* services will be actively promoted give cause for caution in negotiations on health services: Article 51 promotes the removal of barriers to trade in the context of “consumer policy and protection of consumer health”. Article 46, noting adherence to WTO TRIPS regime, was signed in 2000 prior to the WTO November 2001 Doha Declaration on the TRIPS Agreement and Public Health recognising public health concerns.

The IEPA also make provision for trade liberalisation, but only cover trade in goods. Trade in services will be covered by the full EPA. While there are numerous provisions with respect to development finance and capacity building, these are generally phrased and do not make specific mention of the health sector. There is no specific provision or commitment in the ESA-EU IEPA that can be read as protecting or enhancing the health sector in the ESA countries, nor as putting in place specific modalities for realising the health Millennium Development Goals.

Article 53 of the IEPA makes provision for negotiations on trade in services. ESA countries may elect to exclude trade in *health* services. Indeed ESA countries have no obligation to trade in health services. Under conditions of unequal access and differentials in coverage, ESA governments may justly feel that they cannot reduce government authorities to regulate providers, compel cross subsidies, increase risk pools, manage health worker migration and other measures needed to ensure universal health care coverage. Hence the 4th Ordinary Session of the AU Conference of Ministers of Trade stated in April 2006: “*We shall not make services commitments in the EPAs that go beyond our WTO commitments and we urge our EU partners not to push our countries to do so.*” Both in respect of this justified caution, and to ensure that trade in other sectors does not undermine national health sector policies, ESA negotiators will need to advance positions that protect public health and health care.

Ensuring compliance with existing health and human rights commitments

The negotiations will need to be compliant with the international treaties and conventions that both ESA and EC countries are signatory to, and to the African and national constitutional provisions in ESA countries.

| Convention/ Treaty | Commitment on health |
|--|---|
| Charter of the United Nations (1945) http://www.un.org/aboutun/charter/ | Art 55 commits member states to promote higher standards of living, full employment, and conditions of economic and social progress and development. (*) |
| Universal Declaration of Human Rights (1948) http://www.un.org/Overview/rights.html | Article 25 recognises that everyone has the right to a standard of living adequate for the <i>health and well being</i> of themselves and of his family, including food, clothing, housing and <i>medical care</i> and necessary social services, and special note is made of women and children’s needs. (*) |
| Covenant on Economic, Social and Cultural Rights (1976) http://www.unhchr.ch/html/menus/b/a_cescr.htm | Article 12 commits states to recognise the right of everyone to the enjoyment of the <i>highest attainable standard of physical and mental health, with specific requirements for states</i> . States are to take steps for reduction of mortality, improvement of environmental health, prevention of disease and creation of conditions which would assure to <i>all the medical services they need</i> . (*) |
| Convention on the Rights of the Child (1990) http://www.unhchr.ch/html/menus/b/k2crc.htm | Provides for the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. (*) |
| Convention on the Elimination of all forms of Discrimination against Women (1981) http://www.unhchr.ch/html/menus/b/e1cedaw.htm | The Convention creates obligations for States with respect to the health of women in general, and women living in rural areas in particular and provides for state obligations to take all appropriate measures to eliminate discrimination against women to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. |
| African Charter on Human and Peoples’ Rights (1986) www.africa-union.org/official_documents/ | Article 16 gives every individual the right to enjoy the best attainable state of physical and mental health and also obliges States to take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. (*) |

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| European Social Charter (1961) http://conventions.coe.int/treaty/en/treaties/html/035.htm | Guarantees social and economic rights. Recognises the right of everyone to benefit from any measures enabling the enjoyment of the highest possible standard of health attainable. |
| Abuja Declaration (2000) www.malaria.org.zw/SIR/rbm21.pdf Abuja Declaration (2001) www.u.org/ga/aids/pdf/Abuja_declaration.pdf | Allocation of at least 15% of annual budget to the improvement of the health sector. Avail the necessary resources to improve the comprehensive multisectoral response for the fight against HIV/AIDS, TB and other related infectious diseases. (*) |
| SADC Protocol on Health (1999) www.sadc.int/index/browse/ | Commits states to attain an acceptable standard of health for all citizens; to the Primary Health Care approach; to ensure equitable and broad participation for mutual benefit in regional co-operation in health and to harmonisation of the health sector. |
| COMESA Treaty (1993) www.comesa.int | Articles 110-111 of the Treaty commits the ESA countries which are members of COMESA to co-operate for the development of an effective health delivery system e.g. through facilitation of movement of pharmaceuticals within the Common Market ; in training of manpower to deliver effective health care; and in the designation of national hospitals to be Common Market referral hospitals. |

(*) = Ratified by all ESA states

ESA negotiators will thus need to be vigilant to ensure that the relevant treaties and conventions summarised in the table below are complied with in the negotiations, together with the UN Millennium Development Goals (MDGs) that provide important target areas in health against which commitments have been made globally.

A number of ESA countries also provide guarantees for access to medical services within their constitutions. These guarantees need to be acknowledged in the context of trade negotiations, as they are a limit to government flexibility in such negotiations. Such commitments range from broad protection of rights to life and health to more specific provisions obliging states to provide health services, such as “*equal access to social services run with state funds*” (Ethiopia Constitution Article 41); to “*provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care*” (Malawi Constitution Article 13) or to “*take all practical measures to ensure the provision of basic medical services to the population*” (Uganda Constitution Article 20).

These conventions, treaties and constitutional provisions create obligations to be discharged by the State Parties. ESA governments may thus take positions of caution where clauses in the negotiations on services appear to undermine these commitments. Using the precautionary principle that applies in public health, the burden of proof would be on those promoting clauses that appear to undermine commitments made to show evidence why they do *not* do so.

Ensuring use of full flexibilities within the WTO GATS and TRIPS agreements

ESA countries have the right under the WTO TRIPS agreement to use the flexibilities provided to meet their public health obligations. This includes:

- compulsory licensing, or the right to grant a license, without the permission from the license holder, on various grounds including public health; and
- parallel importation-or the right to import products patented in one country from another country where the price is low.

(Further information on TRIPS flexibilities is found in *EQUINET Policy Brief No 16*). G8 development ministers in 2007, reaffirming their commitment to universal access to HIV/AIDS prevention, treatment and care by 2010 said “*more needs to be done to help lower [drugs] costs, including the use of TRIPS flexibilities to the fullest extent*”.

ESA countries should thus ensure that negotiations

- explicitly include a commitment to the full use of TRIPS flexibilities;
- do not include standards of IP protection that go beyond TRIPS; and
- include provisions for EU political and technical support to ESA countries to use the TRIPS flexibilities and to develop their pharmaceutical industries.

It is equally important for the ESA countries, particularly those that have made health sector commitments, to take full advantage of the GATS Article V flexibilities:

- The current ESA-EU negotiations require ESA countries to negotiate only one service sector, to complete negotiations on services liberalisation within 3 years and to achieve substantial sectoral coverage within 5 years. The GATS provides a greater flexibility in providing for “a reasonable time-frame” that should rather be taken advantage of in the EPA wording.
- GATS Article V gives developing countries flexibilities with respect to the elimination of existing discrimination in the services sector, such as the regulatory provisions which bar foreign services suppliers from operating at the same conditions with local providers. ESA states need to provide for this within the current services negotiations.
- GATS Article V.6 does not prevent the granting of more favourable treatment of service suppliers of parties to an economic integration agreement where that agreement involves **only** developing countries. The ESA-EU EPA involves both developing and developed countries, in this respect the granting of more favourable treatment to intra-ESA service suppliers may be questioned, seriously limiting this GATS flexibility.
- Subsidies give private health sector providers from the rich countries greater advantages and a strong background from which to launch multinational investments. This can operate negatively where such service providers are competing with others from poorer countries. Article XV of GATS attempts to address the adverse effects of unfair subsidies. However, the ESA-EU EPA is not concerned with this issue as it provides that the “provisions of this Title shall not apply to subsidies granted by the Parties.” The ESA group should use the current EPA negotiations to raise their problems with those subsidies that distort trade.

Given that the majority of the ESA countries did not make commitments in the health sector under the GATS, they can still rely on their GATS positions as the basis for not opening negotiations in this sector under the EPA. The GATS does not prevent the exclusion of an entire sector from liberalisation, and not all ESA countries are members of the WTO. Negotiators should thus resist asking ESA countries to submit to a liberalisation process which forces them to take on obligations which they never signed up to, or to a faster pace of liberalisation than that which obtains currently under the WTO process.

Protecting public health and health service access in the EPAs

Protecting public health and access to health services demands more than a defensive posture in the negotiations. ESA countries should go beyond this to ensure that there is a clause protecting public health and recognizing state obligations to protect universal and equitable access to health services. This calls for clauses in the EPA that

- ♦ Recognize the priority for protection of public health as a guiding principle, as provided for in the EU-SADC IEPA.
- ♦ Commits parties to compliance with national, regional and international treaties that recognise health as a human right.
- ♦ Commits parties to allowing government authorities and availing specific resources to the public health sectors of the ESA countries as part of the development dimension of the EPA.

- ♦ Commits ESA states to adequate levels and shares of domestic investment in health to meet state obligations in public sector health services on the basis of universal coverage.
- ♦ Commits the EU to avail funds to ESA countries to counter the effect of revenue losses due to the liberalisation of trade in goods. Article 25 of the Cotonou Agreement committing the ACP-EU parties to make available adequate funds for improving health systems, and different dimensions of primary health care.
- ♦ Strengthens the regulatory and enforcement capacities and provisions of ESA states with respect to the operations of the private health sector, both in supply of services, insurance and financing, drug production, training and deployment of personnel and reporting obligations.

The ESA-EU negotiations need to explicitly deal with the movement of health personnel in line with the resolutions of the Regional Health Ministers Conferences of the East, Central and Southern African Health Community, the 2004 World Health Assembly resolution 57.19 on health worker migration and the March 2008 Kampala Declaration and Agenda for Global Action. This includes consideration of commitments and modalities:

- ♦ For governments of receiving countries to notify governments of sending countries of the number of health workers employed, their professional status and their contractual rights and obligations, and provisions to provide equal treatment to health workers recruited from ESA states with the local health workers.
- ♦ Supporting ESA states to register and monitor their professional health workers.
- ♦ To restrict unethical health personnel recruitment and employment practices.
- ♦ To compensate ESA countries through investment and tax remittance arrangements for the loss of health professionals trained in ESA countries who migrate permanently to the EU;
- ♦ To provide technical and resource support to health professional training in ESA, and
- ♦ To provide overseas development aid for health programmes in a manner that integrates with national financing arrangements and plans to avoid outflows of critical health personnel from public health services.

It is necessary to place the health sector as part of the development chapter of the comprehensive EPA: implementation of article 34 of the Cotonou Agreement. This entails the negotiation of technical and development finance assistance targeted at the health sector as part of the sustainable development cooperation as envisaged under article 34 of the Cotonou Agreement.

Information and monitoring

The precautionary principle in public health means that in this area of trade, as in other areas of economic activity, it is necessary to insist that impact assessment studies should be conducted and publicly reported on where there is reasonable presumption of impacts on health and access to health care of a trade measure. Towards this a review clause needs to be inserted to provide for this. ESA negotiators should further call for a comprehensive health sector impact assessment before any commitments are made in the negotiations.

Summary: The right to health is not for sale

The negative lessons of recent epidemics of disease, like cholera, of rising levels of maternal mortality and malnutrition, point to the fact that governments as a whole and not just health ministries have obligations to ensuring public health that cannot be ignored. Equally the recent fall in HIV prevalence demonstrates what can be achieved through national action and international solidarity.

The negotiators on the services agreement carry the responsibility to ensure that their actions protect health in ESA. Towards this, this brief outlines that negotiators should

- i. Explicitly include the commitment to interpret and implement any clauses in a manner supportive of ESA countries right to protect public health;
- ii. Exclude any commitments to liberalise health services under the EPA, reserve the right for government to determine any pace or form of liberalisation nationally, without time restriction;
- iii. Recognise and ensure compliance of the services negotiations with existing health and human rights commitments at EU and ESA level;
- iv. Locate the health sector as part of the development chapter of the comprehensive EPA
- v. Ensure full use of TRIPS and GATS flexibilities and EU capacity and resource support for implementation of these flexibilities;
- vi. Include commitment to adequate investment from both ESA states and EU to the health sector, to meet requirements for universal health care coverage, and counter the effect of public sector revenue losses due to other areas of trade liberalization;
- vii. Include provisions to strengthen the regulatory and enforcement capacities and provisions of ESA states with respect to the operations of the private health sector.
- viii. Include a requirement for health impact assessments in any health related sector where there may be impacts on health, prior to commitments being made;
- ix. Ensure adequate public reporting on the negotiations within EU and ESA to facilitate public and parliamentary dialogue on the proposed provisions.

Further resources

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